Preferred Health Partnership of Tennessee, Inc.

For the Period
January 1, 1998, Through June 30, 1999

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STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
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John G. Morgan
Comptroller

July 31, 2000

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable C. Warren Neal, Ph.D., Commissioner
Department of Finance and Administration
First Floor, State Capitol
Nashville, Tennessee 37243-0285

Ladies and Gentlemen:

Pursuant to the agreement between the Comptroller of the Treasury and the Department of Health, the Division of State Audit performs examinations of managed care organizations participating in the Tennessee TennCare Program under Title XIX of the Social Security Act.

Submitted herewith is the report of the examination of Preferred Health Partnership of Tennessee, Inc., for the period January 1, 1998, through June 30, 1999.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/pn
00/027
cc: Mark Reynolds

State of Tennessee

Audit Highlights

Comptroller of the Treasury Division of State Audit

Audit Report
Preferred Health Partnership of Tennessee, Inc.
For the Period January 1, 1998, Through June 30, 1999

Findings

Deficiencies in Claims Processing System
PHP has not fulfilled contract reporting requirements and processing efficiency requirements specified by the TennCare contract (page 7). This finding is repeated from the prior audit.

Deficiencies in Provider Contract Language
PHP did not include in the provider agreements all requirements specified by the TennCare contract (page 9). This finding is repeated from the prior audit.

"Audit Highlights" is a summary of the audit report. To obtain the complete audit report, which contains all findings, recommendations, and management comments, please contact

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Preferred Health Partnership of Tennessee, Inc.
For the Period January 1, 1998, Through June 30, 1999

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For the Period January 1, 1998, Through June 30, 1999

INTRODUCTION

PURPOSE AND AUTHORITY OF THE EXAMINATION

The terms and conditions for authorizing the TennCare Program, as well as the contracts between the state of Tennessee and the managed care organizations (MCOs) require that examinations of the managed care organizations be conducted by the Tennessee Comptroller's Office. The contract between the Tennessee Department of Health and the State Comptroller's Office also contains a provision requiring the examinations.

Under their contract with the state, the MCOs have asserted to comply with stated requirements regarding their provision of services to TennCare enrollees. The purpose of our examination is to render an opinion on the MCOs' assertions that they have complied with certain financial related requirements of their contract with the state.

BACKGROUND

The Tennessee Department of Finance and Administration is the single state agency responsible for administering the TennCare Program and the TennCare Partners Program. On January 1, 1994, the TennCare Program began as an approved federal waiver replacing the then existing Medicaid Program. TennCare encompasses all services other than mental health and long-term care. On July 1, 1996, the TennCare Partners Program was initiated. TennCare Partners, which functions in the same manner as the regular TennCare Program, covers mental health services. Long-term care continues to be excluded from all TennCare waivers. The state contracts with private health maintenance organizations to provide TennCare services to beneficiaries. The health maintenance organizations (HMOs) are referred to as "managed care organizations" (MCOs).

Recipients who meet Medicaid eligibility standards are enrolled in the TennCare Program and TennCare Partners Program. In addition, certain uninsured and uninsurable individuals are eligible for enrollment. Uninsured persons may be required to pay a monthly premium. The contracting MCO provides care for TennCare enrollees for a stated monthly capitation fee. The MCOs in turn arrange for a network of hospitals, doctors, and other health care providers to furnish health care services for persons enrolled in the plan. Essentially, the program functions much the same as a conventional health care delivery system under managed care.

Preferred Health Partnership of Tennessee, Inc., is a wholly owned subsidiary of PHP Companies, Inc. Effective January 1, 1994, Preferred Health Partnership of Tennessee, Inc., contracted with the State of Tennessee as a preferred provider organization (PPO) to provide medical services under the newly established TennCare Program. Effective January 1, 1997, PHP no longer contracted as a PPO, but as a health maintenance organization (HMO).

At December 31, 1998, the enrollment in the TennCare program for PHP was approximately 92,000 members. At June 30, 1999, the enrollment in the TennCare program for PHP was approximately 82,000 members.

PHP files quarterly and annual statements with the Tennessee Department of Commerce and Insurance. This department uses the information filed in these reports to determine if the plan meets the minimum requirements for statutory reserves. The statements are filed on a *statutory* basis of accounting, which differs from generally accepted accounting principles in that "admitted" assets must be easily converted to cash to pay for outstanding claims. "Nonadmitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and are reduced from equity.

The annual statement for the year ended December 31, 1998, reported $50,796,393 in plan assets; $41,024,330 in liabilities; and $9,772,063 net worth. A separate balance sheet for TennCare operations is not required for annual statement purposes. A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1998, reported total revenues of $135,035,448; medical expenses of $142,370,352; and administrative expenses of $23,622,015, resulting in net loss of $30,956,919. Revenue comprises $131,739,823 in capitation fee payments from TennCare; $2,238,769 in investment income; and $1,056,856 in other revenue. Medical expenses represent 106 percent of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 16 percent of capitation fee payments from TennCare.

The quarterly statement for the quarter ended June 30, 1999, reported $45,750,094 in plan assets; $37,298,323 in liabilities; and $8,451,771 net worth. A separate balance sheet for TennCare operations is not required for annual statement purposes. A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1998, reported total revenues of $58,751,566; medical expenses of $53,510,095; and administrative expenses of $7,060,743, resulting in net loss of $1,819,272. Revenue comprises $56,840,168 in capitation fee payments from TennCare; $1,346,122 in investment income; and $565,276 in other revenue. Medical expenses represent 94 percent of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 10 percent of capitation fee payments from TennCare.

SCOPE OF THE EXAMINATION

Our examination covers certain financial related requirements of the contract between the state and Preferred Health Partnership of Tennessee, Inc., for the period January 1, 1998, to June 30, 1999. The requirements covered are referred to under management's assertions specified later in the Independent Accountant's Report. Our examination does not cover those portions of the contract concerning quality of care and clinical and medical requirements.

PRIOR EXAMINATION FINDINGS

The previous examination of Preferred Health Partnership of Tennessee, Inc., for the period January 1, 1995, through December 31, 1997, included the following findings:

Failure to Maintain Minimum Equity Requirements and Deficiency in Financial Reporting

Preferred Health Partnership of Tennessee, Inc., (PHP) failed to maintain minimum equity requirements. The annual statement for the year ended December 31, 1997, contained deficiencies.

Deficiency in Claims Processing System

Preferred Health Partnership of Tennessee, Inc., did not adhere to contract reporting requirements and processing-efficiency requirements. PHP's explanation of benefits did not effectively communicate to TennCare members any amounts owed to the medical provider. All data elements required for individual encounter/claims data reporting were not accurately recorded from claims providers submitted. PHP did not coordinate members' out-of-pocket expense with TBH. An electronic billing option was not offered to PHP's contracted providers.

Deficiencies in Provider Agreements

Preferred Health Partnership of Tennessee, Inc., did not include all requirements specified by the TennCare contract in the provider agreements.

The findings concerning deficiencies in the claims processing system and deficiencies in provider agreements will be repeated in the current report (see the Findings and Recommendations section of this report).

RESULTS OF THE EXAMINATION

Our examination of the plan revealed discrepancies in the claims processing system and provider agreements. These discrepancies are further discussed in the Findings and Recommendations section of the report.

Subsequent material events and corrections affected the reporting of the operations of PHP for the period January 1, 1998, through June 30, 1999. PHP's equity was adjusted by the Division of State Audit as follows:

- Adverse Selection Payments totaling $2,920,602 for 1998 received in 1999 were not recorded as receivables on the 1998 annual statement. On the June 30, 1999, quarterly statement, these 1998 adverse selection payments are recorded as deferred assets. An adjustment for these payments results in an increase to equity at June 30, 1999, of $2,920,602.

- Capitation fee payments from TennCare on the June 30, 1999, quarterly statement are understated by $200,000.

The effect of these adjustments will increase reported equity from $8,451,771 to $11,572,373 as of June 30, 1999. PHP's minimum net worth requirement at June 30, 1999, was $5,269,593 per the TennCare contract.

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Independent Accountant's Report

November 18, 1999

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable C. Warren Neal, Ph.D., Commissioner
Department of Finance and Administration
First Floor, State Capitol
Nashville, Tennessee 37243-0285

Ladies and Gentlemen:

We have examined management's assertions included in its representation letter dated November 18, 1999, that Preferred Health Partnership of Tennessee, Inc., complied with the following requirements during the period of January 1, 1998, through June 30, 1999.

- The organization has complied with its contractual duty to provide certain member services to its enrollees such as membership cards, provider directories, assignment of a primary care provider, and information on filing grievances.

- Assets and liabilities are properly classified as "admitted" or "nonadmitted" on the annual National Association of Insurance Commissioners (NAIC) report which is completed on a "statutory basis of accounting" and filed with the state.

- The organization is in compliance with the minimum equity requirements as specified in the contract with the state.

As discussed in management's representation letter, management is responsible for ensuring compliance with those requirements. Our responsibility is to express an opinion on management's assertions about the organization's compliance based on our examination.

Our examination was made in accordance with standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about the compliance of Preferred Health Partnership of Tennessee, Inc., with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on the compliance of Preferred Health Partnership of Tennessee, Inc., with specified requirements.

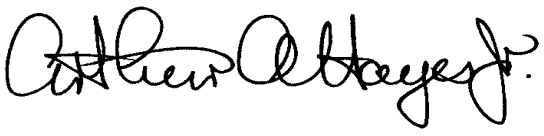
Our examination disclosed the following material noncompliance applicable to Preferred Health Partnership of Tennessee, Inc.:

- Agreements with subcontractors and with medical providers do not contain the required provisions as specified in the contract with the state.
- The organization is not in compliance with contractual claims processing requirements.
- The organization is not in compliance with contractual reporting requirements.

In our opinion, except for the material noncompliance described in the above paragraph, management's assertions that Preferred Health Partnership of Tennessee, Inc., complied with the aforementioned requirements for the period January 1, 1998, through June 30, 1999, is fairly stated, in all material respects.

This report is intended solely for the use of the Tennessee General Assembly and the Tennessee Department of Health. However, this report is a matter of public record and its distribution is not limited.

Sincerely,



Arthur A. Hayes, Jr., CPA, Director
Division of State Audit

AAH/pn

FINDINGS AND RECOMMENDATIONS

1. Deficiencies in claims processing system

Finding

Preferred Health Partnership of Tennessee, Inc., did not fulfill contract reporting requirements and processing efficiency requirements. A review of 60 claims for services provided from January 1, 1998, through June 30, 1999, revealed the following:

a) PHP did not meet the claims processing requirements specified by the TennCare contract. Clean claims submitted by providers for medical services were not always processed within the 40-day requirement. The processing lags include an adjustment to the adjudication date. PHP's final adjudication date used to calculate the lag is the date checks and remittance advices are printed. The processing lag has been adjusted to calculate the lag, using the date the checks and remittance advices are mailed. Of the 60 claims examined, 39 were clean claims with the following time lags:

   22 claims within 30 days (51% of the 60 claims examined))
   8 claims within the 31 to 40 days (19%)
   2 claims within 41 to 60 days (5%)
   7 claims over 60 days (16%)

b) Four claims did not pay amounts in agreement with negotiated rates.

c) Five claims did not have all data elements recorded from the claim.

   One claim's date of service in the system was incorrect and a diagnosis code was not entered into the system.

   One claim had the number of units incorrectly entered into the system.

   Two claims did not have all diagnosis codes recorded in the system.

   One claim had incorrect date of service entered in the system.

d) Copies of remittance advices were not provided to auditors.

e) The claims processing system does not appear to accumulate out-of-pocket amounts.

f) Copies of the uninsured explanation of benefits were not provided to auditors.

g) One claim was denied appropriately but with the wrong code.

h) One claim was paid when it should have been denied.

i) Two claims were appropriately denied but did not include all possible denial codes.

j) One claim was denied as not covered when it should not have been denied.

The inaccuracies and inefficiencies in the claims processing system indicate PHP's failure to fulfill the claims processing requirements of the TennCare contract.

Recommendation

PHP should adhere to contract reporting requirements and processing efficiency requirements for claims processing. Claims should be paid according to the correct fee schedule or contract pricing methodologies. All date elements required for individual encounter/claims data reporting should be recorded from claims submitted by providers. All possible reasons for denial should be communicated to the provider. Claims should be paid or denied in the time required by the TennCare contract. Out-of-pocket expenses should be accumulated.

Management's Comment

Management concurs with the audit recommendations with one exception. Our Amisys software system reports one reason for claims denial when a claim is adjudicated as a denial. Configuration and reprogramming of our systems to add all possible reasons for denial on the remittance advice to provider is not economically feasible.

We concur that claims should be paid according to the correct fee schedule or contract pricing methodologies. Significant work is ongoing to insure our claims systems price services paid at the appropriate level of reimbursement. We will be matching our provider fee schedules to extracts from our claims processing systems to guard against manual data errors in the loading of fee schedule information.

Management concurs that all data elements required for individual encounter/claims data reporting should be recorded from claims submitted by providers. Some errors, those related to incorrect dates, identified in the audit were a result of human intervention to redirect claims that had been loaded to the wrong claims processing system. These errors were most frequent during the transition from our CSC MHC claims processing system to the Amisys claims processing system effective January 1, 1999.

As we continue to see fewer claims with dates of service prior to this date, the opportunity for these errors will be minimized. We are also working on electronic sorting capabilities for images loaded to our Macess electronic imaging and workflow system. These improvements should enhance our efficiency in the mail and avoid human error in the mail sorting process.

Errors related to omitted diagnoses codes on the claims identified were a result of human error. Our training has been updated to re-emphasize the need to capture all diagnoses. We do have a system limitation of 3 diagnoses for medical claims and 15 diagnoses for hospital claims.

We concur with the requirement that claims be paid or denied within timeframes required by the TennCare contract. Our processing efficiency has improved significantly with the Amisys system, but we have been guilty of holding claims in a pended status in an attempt to obtain additional information to properly adjudicate a claim when initially submitted. We will be more conscious of the contract deadlines and deny claims for lack of information as appropriate when timeframes dictate.

Management concurs with the need to track out-of pocket expenses. On 1/1/97 PHP TennCare entered into an alternative cost sharing arrangement with the Bureau for our members. This arrangement requires no deductibles, as the members have straight copays for doctor office visits, hospital emergency room and pharmacy. Pharmacy data is not housed on the Amisys system due to a subcontracted vendor arrangement. Because of this, copay tracking is done through the PHP TennCare data warehouse. It is our understanding that the BHO has not been enforcing cost sharing responsibilities for members and therefore there is no out of pocket data to place in the warehouse for tracking purposes. Through a data extract at the for paid claims in 1999, it was identified that no PHP TennCare member had met or exceeded the $1,000 dollar out of pocket limit. We will continue to monitor the out of pocket amounts of our membership throughout 2000 on a regular basis.

Copies of explanation of benefits or remittance advices were mailed to the Comptroller Office two weeks after the examination. These were provided at a later time due to the need to request copies from Perot.

2. Deficiencies in provider contract language

Finding

Preferred Health Partnership of Tennessee, Inc., did not comply with the TennCare contract requirements for provider agreements. The contracts did not contain all requirements as specified in Section 2-18 of the contract between TennCare and Preferred Health Partnership of Tennessee, Inc. Language describing the following requirements is excluded or deficient in contracts between PHP and its providers:

- Specify that the provider may not refuse to provide medically necessary or covered preventive services to a TennCare patient for non-medical reasons, including, but not limited to, failure to pay applicable deductibles, copayments, and/or special fees. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

- Provide that emergency services be rendered without the requirement of prior authorization of any kind;

- Require that any and all records be maintained for a period not less than five (5) years from the close of the agreement and retained further if the records are under review or audit until the review or audit is complete. Said records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of authorized representative of the MCO or TENNCARE;

- Whether announced or unannounced, provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and appeal procedures established by the MCO and/or TENNCARE;

- Provide for submission of all reports and clinical information required by the MCO;

- Provide for prompt submission of information needed to make payment;

- Provide for payment within thirty (30) calendar days to the provider upon receipt of a clean claim properly submitted by the provider;

- The provider shall indemnify and hold TennCare harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TennCare and the MCO.

- The agreement incorporates by reference all applicable federal and state laws or regulations, and that revision of such laws or regulations shall automatically be incorporated into the agreement, as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, PHP and the provider agree to negotiate such further amendments as may be necessary to correct any inequities.

- Specify that both parties recognize that in the event of termination of the agreement between the MCO and TennCare, the provider agreement shall terminate immediately and the provider shall immediately make available, to TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the MCO/provider agreement. The provision of such records shall be at no expense to TennCare.

- The Contractor shall submit the proposed arbitration procedure, existing alternative arbitration procedure, or any subsequent modification to the arbitration procedure to the

Tennessee Department of Commerce and Insurance, TennCare Division for review and approval/denial within 30 calendar days after receipt. If a modification to the arbitration procedure is sent, it shall be sent Certified Mail-Return Receipt Requested.

- Specify that the provider shall be required to accept TennCare reimbursement amounts for services provided under the agreement between the provider and the MCO to TennCare enrollees and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the MCO;

- Specify that the provider must adhere to the Quality of Care Monitors included in the TennCare contract.

- The provider shall have at least 120 calendar days from the date of rendering a health care service to file a claim and no more than 180 calendar days to file an initial claim with the MCO.

- Specify that the provider will comply with the appeal process including but not limited to assisting an enrollee by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review;

- Enrollees have the right to appeal adverse decisions that affect services. Notices of the right to appeal adverse decisions shall be displayed by the provider in public areas of the providers' facility(s).

- At the next renewal, but no later than December 31, 1998, require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect; and

- All provider agreements must include language which informs providers of the package of benefits that EPSDT offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. For existing provider agreements, this may be accomplished at the next renewal, but no later than December 31, 1998.

Recommendation

PHP should comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements should contain all items as specified in Section 2-18 of the TennCare contract. All subcontracts should be approved by the TennCare Bureau.

Management's Comment

Management acknowledges that at the beginning of the audit period, some of the provider agreements did not contain all of the TennCare contractually required language. Amendments were sent to all PHP TennCare participating providers in the fall of 1998 (the September 1998 Amendment) which complied with all necessary TennCare contract language stipulations. The provider agreement templates were revised and updated with all the regulatory language additions, changes and deletions. Current provider templates and any new provider or organizational entity contracts reflect the changes to the TennCare Risk Agreement and the provisions that are contained within that Agreement and the Amendments to that Agreement.